92-93

No. ———

Supreme Court, U.S.
FILED
JUL 13 1992
OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

CURTIS SNEEDE, *et al.*,

Petitioners,

v.

KENNETH KIZER, Director,
California Department of Health Services,

and

LOUIS W. SULLIVAN, M.D., Secretary,
U.S. Department of Health
and Human Services,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

---

PETITION FOR WRIT OF CERTIORARI

EVELYN R. FRANK
LEGAL AID SOCIETY OF
ALAMEDA COUNTY
1440 Broadway, Suite 700
Oakland, California 94612
(510) 451-9261

MICHAEL C. PARKS
NATIONAL HEALTH LAW
PROGRAM, INC.
2639 South La Cienega Boulevard
Los Angeles, California 90034
(213) 204-6010

MARSHA BERZON
(Counsel of Record)
MICHAEL RUBIN
ALTSHULER, BERZON, NUSSBAUM,
BERZON & RUBIN
177 Post Street, Suite 300
San Francisco, California 94108
(415) 421-7151

Attorneys for Petitioners

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

56

QUESTION PRESENTED

Whether an action by Medicaid recipients challenging the denial under color of state law of their right to Medicaid benefits under Title XIX of the Social Security Act is an action under the federal Civil Rights Act, 42 U.S.C. § 1983.

PARTIES TO THE PROCEEDING

Petitioners: CURTIS SNEEDE, JUSTIN THOMPSON and GEORGIA THOMPSON, on their own behalf and on behalf of a class consisting of California residents who, at any time on or after May 18, 1988: 1) applied for and/or received Medi-Cal benefits or will apply for and/or receive such benefits; and 2) had or will have income or resources attributed to them from an individual other than a natural or adopted parent or a spouse; and 3) have been or will be determined to be ineligible for Medi-Cal on the basis of such resources; or 4) have been or will be determined to have a share of cost.

Respondents: KENNETH KIZER, Director of the State of California's Department of Health Services; LOUIS W. SULLIVAN, M.D., Secretary of the United States Department of Health and Human Services.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
PARTIES TO THE PROCEEDING	ii
TABLE OF AUTHORITIES	iv
OPINIONS BELOW	2
JURISDICTION	2
STATUTES AND REGULATIONS INVOLVED	2
STATEMENT OF THE CASE	4
REASONS FOR GRANTING THE PETITION	6
CONCLUSION	9

TABLE OF AUTHORITIES

CASES Page

Edelman v. Jordan, 415 U.S. 651 (1974) 7
Hal Roach Studios, Inc. v. Richard Feiner & Co., 896 F.2d 1542 (9th Cir. 1990) 5
King v. Atiyeh, 814 F.2d 565 (9th Cir. 1987) 5
Maine v. Thiboutot, 448 U.S. 1 (1980) ..... *passim*
Nebraska Health Care Ass'n v. Dunning, 778 F.2d 1291 (8th Cir. 1985) 7
Rose v. Heintz, 806 F.2d 389 (2d Cir. 1986) 7
Sacramento Coca-Cola Bottling Co. v. Chauffeurs, Teamsters and Helpers Local 150, 440 F.2d 1096 (9th Cir. 1971) 5
Estate of Smith v. O'Halloran, 930 F.2d 1496 (10th Cir. 1991) 7
Washer v. Bullitt Co., 110 U.S. 558 (1884) 4
West Virginia University Hospitals, Inc. v. Casey, 111 S. Ct. 1138 (1991) 7
Wilder v. Va. Hosp. Ass'n, 496 U.S. 498 (1990) 8

STATUTES and REGULATIONS

28 U.S.C. § 1254(a)(1) 2
28 U.S.C. § 1292(a)(1) 5
28 U.S.C. § 2412(b) ..... *passim*
42 U.S.C. § 1396a(a)(17)(D) 3, 4, 6
42 U.S.C. § 1983 ..... *passim*
42 U.S.C. § 1988(b) ..... *passim*
22 C.C.R. § 50373 8

MISCELLANEOUS

Miller & Kane, Federal Practice & Procedure, § 1476 4

IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

No. ———

CURTIS SNEEDE, *et al.*,
Petitioners,

v.

KENNETH KIZER, Director,
California Department of Health Services,

and

LOUIS W. SULLIVAN, M.D., Secretary,
U.S. Department of Health
and Human Services,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

---

PETITION FOR WRIT OF CERTIORARI

Petitioners Curtis Sneede *et al.* respectfully petition this Court to issue a Writ of Certiorari to review the decision of the United States Court of Appeals for the Ninth Circuit entered in this case on December 13, 1991, and to summarily reverse that decision insofar as it held in Part V that petitioners' action was not an action brought under 42 U.S.C. § 1983.

OPINIONS BELOW

The unpublished opinion of the United States Court of Appeals for the Ninth Circuit is reprinted in the Appendix to this Petition at page 1a. The Ninth Circuit's Order denying petitioners' Petition for Rehearing is reprinted in the Appendix at page 11a.

The January 5, 1990 Order of the United States District Court for the Northern District of California granting summary judgment to petitioners and against the state respondents is reported at 728 F.Supp. 607 (N.D. Cal. 1990) and is reprinted in the Appendix at page 14a. The unreported June 8, 1990 Order of the District Court pertaining to implementation is reprinted in the Appendix at page 27a.

JURISDICTION

The decision of the United States Court of Appeals for the Ninth Circuit was entered on December 13, 1991. A timely Petition for Rehearing was denied by the Ninth Circuit on April 13, 1992. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(a)(1).

STATUTES AND REGULATIONS INVOLVED

42 U.S.C. § 1983 provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

42 U.S.C. § 1988(b) provides:

> In any action or proceeding to enforce a provision of sections 1981, 1981a, 1982, 1983, 1985, and 1986 of this title, title IX of Public Law 92-318, or title VI of the Civil Rights Act of 1964, the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee as part of the costs.

28 U.S.C. § 2412(b) provides:

> Unless expressly prohibited by statute, a court may award reasonable fees and expenses of attorneys, in addition to the costs which may be awarded pursuant to subsection (a), to the prevailing party in any civil action brought by or against the United States or any agency or any official of the United States acting in his or her official capacity in any court having jurisdiction of such action. The United States shall be liable under the common law or under the terms of any statute which specifically provides for such an award.

42 U.S.C. § 1396a(a)(7)(D) provides:

> (a) A State plan for medical assistance must—
>
> * * * * *
>
> (17) . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which
>
> * * * * *
>
> (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individuals's sponse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind and or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); . . .

STATEMENT OF THE CASE

More than 10 years ago, this Court held in *Maine v. Thiboutot*, 448 U.S. 1 (1980), that actions by Social Security Act beneficiaries to recover benefits due under that Act are brought under 42 U.S.C. § 1983. The Ninth Circuit in this case, reaching to decide an issue that was neither briefed nor argued by the parties, completely overlooked *Maine v. Thiboutot* and held, without presenting *any* supporting analysis or case law, that 42 U.S.C. § 1983 does *not* encompass actions brought by Medicaid beneficiaries to recover statutory benefits under Title XIX of the Social Security Act. This decision, which is utterly without legal support, should be summarily reversed.

Petitioners Curtis Sneede *et al.* filed this action in California state court on May 17, 1989, naming as defendants the Director of California's Department of Health Services, the Department of Health Services, the Director of California's Department of Finance and the Department of Finance ("state respondents"), and alleging that California was denying them Medicaid benefits due under federal law.

The state respondents removed this case to federal court on the ground that it arose under a federal statute, 42 U.S.C. § 1396a(a)(17)(D). On October 26, 1989, petitioners filed a motion for partial summary judgment. One month later, on November 28, 1989, petitioners filed a First Amended Complaint, which added as defendants the United States Department of Health and Human Services and the Secretary of Health and Human Services ("federal respondents").[1]

---

[1] That First Amended Complaint then became the operative pleading. Where a pleading has been amended, the original pleading "no longer performs any function in the case . . . ." Wright, Miller & Kane, Federal Practice & Procedure, § 1476 at 557; *Washer v. Bullitt Co.*, 110 U.S. 558, 562 (1884). As the Ninth Circuit itself has recognized, "'the amended complaint *supersedes* the original,

On January 5, 1990, the District Court granted petitioners' motion for partial summary judgment, holding that the state respondents had deprived petitioners of their right to benefits under the federal Medicaid Act. On June 8, 1990, the District Court issued a further order regarding implementation of its January 5, 1990 Order.[2]

The state and federal respondents appealed the June 8, 1990 Order to the Ninth Circuit pursuant to 28 U.S.C. § 1292(a)(1). On December 13, 1991, the Ninth Circuit affirmed the June 8, 1990 Order on the merits, but denied petitioners attorneys' fees, stating *inter alia*:

> Section 1988 permits a court to award attorneys fees in actions brought to enforce section 1983 and other specific civil rights laws. *See* 42 U.S.C. § 1988 (1988). *This action was not brought under any of those laws and so Appellees have no remedy against state Appellants under section 1988.* It follows, therefore, that Appellees also have no remedy against the federal Appellants under [28 U.S.C.] section 2412(b) [which allows fees against the federal government "to the same extent that any other party would be liable . . . under the terms of any statute which specifically provides for such an award"—*e.g.*, § 1983].

App. 9a. None of the parties had briefed the fees issue or the § 1983 issue prior to the Ninth Circuit's ruling.[3]

---

the latter being treated thereafter as non-existent.'" *Sacramento Coca-Cola Bottling Co. v. Chauffeurs, Teamsters and Helpers Local 150*, 440 F.2d 1096, 1098 (9th Cir. 1971) (quoting *Loux v. Rhay*, 375 F.2d 55, 57 (9th Cir. 1967)) (emphasis added); *Hal Roach Studios, Inc. v. Richard Feiner & Co.*, 896 F.2d 1542, 1546 (9th Cir. 1990); *King v. Atiyeh*, 814 F.2d 565, 567 (9th Cir. 1987).

[2] On August 22, 1990, the District Court applied its January 5 and June 8, 1990 orders to the federal respondents as well; and on December 11, 1990, the District Court granted summary judgment against the federal respondents "for the reasons set forth in [the District Court's] January 5 . . . 1990 order[]."

[3] The fees issue arose merely because petitioners had notified the Ninth Circuit, as required by Ninth Circuit Rule 39-1.6, that if

Petitioners sought rehearing of the Ninth Circuit's denial of fees on the ground that the First Amended Complaint had expressly alleged that the action was brought to enforce § 1983 and that under *Maine v. Thiboutot*, 448 U.S. 1 (1980), an action seeking Medicaid benefits under Title XIX of the Social Security Act *is* an action under 42 U.S.C. § 1983. The Ninth Circuit denied the Petition for Rehearing without comment on April 13, 1992. App. 11a.

REASONS FOR GRANTING THE PETITION

This case was brought as a class action against the California Department of Health Services and the U.S. Secretary of Health and Human Services for violation of the federal Medicaid Act, 42 U.S.C. § 1396 *et seq.*, which is Title XIX of the Social Security Act. Petitioners' First Amended Complaint expressly alleged that respondents' violation of the Medicaid Act violated petitioners' rights under the Civil Rights Act, 42 U.S.C. § 1983, on the well-established theory that § 1983 encompasses suits against persons acting under color of state law who deprive an individual of rights protected by the "laws" of the United States.[4]

---

they prevailed, they "intend[ed] to seek attorneys fees from the state defendants pursuant to 42 U.S.C. § 1988 and from the Secretary pursuant to 28 U.S.C. § 2412(b) and (d)" and would "ask that the issue of fees be remanded so that it may be consolidated with pending proceedings in the District Court." Ninth Circuit Brief for Plaintiffs and Appellees at 3.

[4] *See* First Amended Complaint, ¶ 1 ("this suit is brought, pursuant to 42 U.S.C. § 1983, to redress the deprivation under color of state law of rights, privileges, and immunities secured to plaintiffs by the laws of the United States.") Petitioners also expressly sought attorneys' fees under the Civil Rights Attorneys' Fees Awards Act, 42 U.S.C. § 1988, which provides fees to a prevailing plaintiff "[i]n any action or proceeding to enforce a provision of . . . § 1983." *See* First Amended Complaint, Prayer for Relief, ¶ 6 (seeking "costs of suit and reasonable attorneys fees pursuant to 42 U.S.C. § 1988 and 42 U.S.C. § 2412(b), (d)").

The Ninth Circuit, without explanation or analysis, concluded that petitioners were not entitled to § 1983 fees because this was not a civil rights action within the meaning of § 1983. That conclusion is directly contrary to the plain statutory language of 42 U.S.C. § 1983 and § 1988. It is also contrary to this Court's construction of that language in *Maine v. Thiboutot*, *supra*, which upheld an award of § 1988 fees to plaintiffs who had prevailed against state defendants on a federal Social Security Act claim seeking AFDC benefits.

The Civil Rights Attorney Fees Awards Act of 1986, 42 U.S.C. § 1988, provides fees to prevailing plaintiffs "[i]n any action or proceeding to enforce a provision of [42 U.S.C. §] 1983." Section 1983, in turn, applies to "[e]very person who, under color of any . . . regulation . . . of any State . . . subjects . . . any . . . person . . . to the deprivation of any rights . . . secured by the Constitution *and laws* . . . ." (Emphasis added). Read together, these statutes clearly express Congress' intent to provide attorneys' fees whenever a governmental defendant acts under color of state law in depriving a plaintiff of federal statutory rights under the Social Security Act, as this Court and many lower courts have held.[5]

---

[5] *See, e.g., Maine v. Thiboutot*, *supra*, 448 U.S. at 4-9; *West Virginia University Hospitals, Inc. v. Casey*, 111 S.Ct. 1138 (1991) (denying expert fees, but otherwise approving fee award under § 1988 against state officials for, *inter alia*, Medicaid Act violations); *Edelman v. Jordan*, 415 U.S. 651, 675 (1974), *citing Rosado v. Wyman*, 397 U.S. 397 (1970) ("suits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act on the part of participating States"); *Estate of Smith v. O'Halloran*, 930 F.2d 1496 (10th Cir. 1991) (recognizing right to fees in § 1983 action for failure to promulgate patient-oriented nursing home regulations as required by Medicaid Act); *Rose v. Heintz*, 806 F.2d 389 (2d Cir. 1986) (§ 1988 fees awarded to successful Medicaid claimants challenging "deeming" of step-parents' income); *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1295 (8th Cir. 1985) (awarding fees to medical care facility operators who successfully challenged Medicaid reimbursement).

This Court's opinion in *Maine v. Thiboutot* makes clear that the Medicaid Act, like the Social Security Act of which it is part, is a "law" of the United States within the meaning of 42 U.S.C. § 1983:

> Given that Congress attached no modifiers to the phrase ["and laws"], the plain language of the statute undoubtedly embraces respondents' claim that petitioners violated the Social Security Act. Even were the language ambiguous, . . . any doubt as to its meaning has been resolved by our several cases suggesting, explicitly or implicitly, that the § 1983 remedy broadly encompasses violations of federal statutory as well as constitutional law. . . .

448 U.S. at 4; see also *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498 (1990). Moreover, because respondents in this case acted pursuant to state regulation (22 C.C.R. § 50373), they were undoubtedly acting under color of state law. Accordingly, this *is* an action under 42 U.S.C. § 1983.

The Ninth Circuit's inexplicable conclusion to the contrary is completely without case support. It should be summarily reversed with the directive that this action be remanded to the district court for a determination of whether plaintiffs' counsel—the Legal Aid Society of Alameda County and the National Health Law Program—are entitled to a reasonable attorney's fee for their successful efforts on behalf of the plaintiff class in this important action under the Medicaid Act and 42 U.S.C. § 1983.[6]

---

[6] Just as 42 U.S.C. § 1988 allows fees against state defendants in actions brought under 42 U.S.C. § 1983, 28 U.S.C. § 2412(b) allows fees against federal defendants in such cases, since it allows fees "to the same extent that any other party would be liable . . . under the terms of any statute which specifically provides for such an award." The Ninth Circuit denied fees to petitioners under § 2412(b) on the strength of its earlier conclusion that this was not a § 1983 case, stating that since petitioners "have no remedy against state Appellants under section 1988, [i]t follows, therefore, that Appellees also have no remedy against federal Appellants un-

CONCLUSION

Section 1983 encompasses all claims that a defendant acting under color of state law deprived plaintiffs of rights secured by the laws of the United States. The Medicaid Act is one such law. *Maine v. Thiboutot*, *supra*, 448 U.S. at 4-8. Since petitioners' First Amended Complaint expressly stated that petitioners were asserting a claim under § 1983 (and would be seeking attorneys' fees from the District Court under 42 U.S.C. § 1988), their action was unquestionably an "action under 42 U.S.C. § 1983," and the Ninth Circuit's contrary holding should be summarily reversed.

Respectfully submitted,

EVELYN R. FRANK
LEGAL AID SOCIETY OF
ALAMEDA COUNTY
1440 Broadway, Suite 700
Oakland, California 94612
(510) 451-9261

MICHAEL C. PARKS
NATIONAL HEALTH LAW
PROGRAM, INC.
2639 South La Cienega Boulevard
Los Angeles, California 90034
(213) 204-6010

MARSHA BERZON
(Counsel of Record)
MICHAEL RUBIN
ALTSHULER, BERZON, NUSSBAUM,
BERZON & RUBIN
177 Post Street, Suite 300
San Francisco, California 94108
(415) 421-7151
Attorneys for Petitioners

Dated: July 13, 1992

---

der section 2412(b)." App. 9a. Since the predicate to this conclusion is erroneous (for the reasons stated *supra* at 6-8), so too is its conclusion.

APPENDIX

APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 90-15141

D.C. No. CV-89-1932-TEH

CURTIS SNEEDE, by his guardian ad litem Georgia Thompson; JUSTIN THOMPSON, by his guardian ad litem Georgia Thompson; GEORGIA THOMPSON, on her own behalf and as representative of her sons Curtis Sneede and Justin Thompson,

Plaintiffs-Appellees,

v.

KENNETH KIZER, Director, California Department of Health Services; CALIFORNIA DEPARTMENT OF HEALTH SERVICES; JESSE R. HUFF, Director, California Department of Finance; CALIFORNIA DEPARTMENT OF FINANCE,

Defendants-third-party-plaintiffs-Appellants.

Nos. 90-16143
90-16144

CURTIS SNEEDE, by his guardian ad litem Georgia Thompson; JUSTIN THOMPSON, by his guardian ad litem Georgia Thompson; GEORGIA THOMPSON, on her own behalf and as representative of her sons Curtis Sneede and Justin Thompson,

Plaintiffs-Appellees,

v.

KENNETH KIZER, Director, California Department of Health Services; CALIFORNIA DEPARTMENT OF HEALTH SERVICES; JESSE R. HUFF, Director, California Department of Finance; CALIFORNIA DEPARTMENT OF FINANCE,
Defendants-Appellants,

v.

LOUIS W. SULLIVAN, M.D., Secretary, United States Department of Health & Human Services; DEPARTMENT OF HEALTH & HUMAN SERVICES,
Third-party-defendants.

No. 90-16295

CURTIS SNEEDE,
Plaintiff,

v.

KENNETH KIZER; CALIFORNIA DEPARTMENT OF HEALTH SERVICES;
Defendants-third-party-plaintiffs-Appellees,

v.

LOUIS W. SULLIVAN, M.D., Secretary, United States Department of Health and Human Services,
Third-party-defendant-Appellant.

Appeal from the United States District Court
for the Northern District of California
Thelton E. Henderson, District Judge, Presiding

Argued and Submitted August 22, 1991
San Francisco, California

MEMORANDUM *

[Filed Dec. 13, 1991]

Before: D.W. NELSON, HALL, and FERNANDEZ, Circuit Judges.

On January 5, 1990, the District Court for the Northern District of California enjoined the California Department of Health Services ("DHS") from enforcing a method of determining whether medically needy applicants qualify for Medi-Cal. The court found that the method employed improperly attributed income and resources to Medi-Cal applicants and recipients, in violation of 42 U.S.C. § 1396a(a)(17)(D). *Sneede v. Kizer*, 728 F. Supp. 607 (N.D. Cal. 1990). Pursuant to the court's order, the DHS submitted a revised eligibility plan, which the court accepted in part and rejected in part in its order of June 8, 1990.

The DHS, joined by the Secretary of Health and Human Services ("HHS"), appeals the district court's June 8 ruling that the prorated "needs" standard of the revised eligibility plan violated § 1396a(a)(17)(D). The DHS and the Secretary also appeal that portion of the court's order proposing an alternative "needs" standard that would conform to the requirements of subsection (17)(D).[1]

---

* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by 9th Cir. R. 36-3.

[1] DHS initially also sought review of the court's January 5 order, but has apparently abandoned that appeal. Thus, the only issue presently before this court is the propriety of the June 8 order.

The district court had jurisdiction pursuant to 18 U.S.C. §§ 1331 and 1361. This court has jurisdiction under 18 U.S.C. § 1291(a)(1). We affirm the district court's ruling that the DHS's prorated "needs" standard violates § 1396a(a)(17)(D). Because the district court did not require the DHS to adopt the court's proposed alternative plan, we have no occasion to address the propriety of that plan. Finally, we deny appellees' request for attorneys fees.

I

Pursuant to the district court's January 5 order requiring the DHS to comply with 42 U.S.C. § 1396a(a)(17)(D), the DHS presented to the court a revised method for determining the income and need of each Medi-Cal Family Budget Unit ("MFBU"). For the purposes of determining eligibility and income, the DHS proposed that each MFBU be broken into sub-units, called Mini Budget Units ("MBUs"), to prevent attribution of income in violation of subsection (17)(D). Depending on family relationships and whether a child had separate income or property of her own, the DHS would create as many MBUs as necessary. Thus, a child with income would always be in a separate filing unit, as would stepchildren and mutual children of unmarried parents. Income would then be calculated separately for each MBU. Spousal and parental income would be allocated equally between the spouse or parent and those individuals for whom he or she is financially responsible. The district court accepted this aspect of the DHS's proposed alternative to the invalidated policy.

But the court rejected the DHS's proposed method for assessing an applicant's need. Under the pre-January 5 procedure, need would be determined by comparing the income of the MFBU to the "needs" standard, referred to as "Medically Needy Income Levels" ("MNIL"). Under the revised procedure proposed by the DHS, even though eligibility would be determined by the income of

the MBU, need would not be assessed by comparing that income to the MNIL for that size MBU. Instead, the income of the MBU would be compared to an MNIL prorated across the MFBU. So, for example, the MNIL for an MBU of one carved out of an MFBU of four would not be $600, but $1100 divided by 4, or $275. The district court found this method of determining need invalid because it would permit "deeming" in violation of subsection (17)(D). June 8, 1990 Order at 8. The court rejected on similar grounds the state's argument that it was merely accounting for economies of scale. *Id.* at 8-9.

Suggesting an alternative approach, the court held that prorating would be permissible so long as it was based only on persons who were financially responsible for the applicant under subsection (17)(D). June 8 Order at 17. The court then ordered DHS and the plaintiffs

> to devise a needs methodology that is consistent with section (17)(D) in that:
>
> > (1) it takes into account the applicant's needs in light of all persons who are financially responsible for the applicant under § 1396a(a)(17)(D)—whether included in the MFBU or not, but
> >
> > (2) does not reduce the needs standard based on the presence of persons in the household who are not finanically responsible for the applicant under § 1396a(a)(17)(D).

June 8 Order at 17-18.

II

The interpretation of a statute is a question of law that this court reviews de novo. *Vance v. Hegstrom*, 793 F.2d 1018, 1022 (9th Cir. 1986). Under *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984), federal courts must accord proper deference to the Secretary's interpretation of the Medi-

caid statute. A court need not defer to an agency's interpretation if the construction violates an unambiguous statutory command; but deference is appropriate if the statute is ambiguous or unclear and the agency's interpretation is based on a reasonable construction of the statute. *Id.*; *see also Citizens Action League v. Kizer*, 887 F.2d 1003, 1007 (9th Cir. 1989) (citing *Chemical Mfrs. Ass'n v. Natural Resources Defense Council*, 470 U.S. 116, 125 (1985)), *cert. denied*, 110 S. Ct. 1524 (1990)).

III

Appellants DHS and the Secretary present us with two arguments why the court erred in holding that the DHS's proration plan violated 42 U.S.C. § 1396a(a)(17)(D). We reject both.

A

Appellants first contend that subsection (17)(D) "restricts only the method states use for calculating available income, not the method used to determine need standards against which that available income is measured." They argue that because available income is not taken into account in determining the MNIL, the proration plan does not "deem" in violation of subsection (17)(D).

The district court properly rejected this argument. A court owes no deference to an agency's interpretation of a statute when the statute is unambiguous. *See Chevron*, 467 U.S. at 842-43. Subsection (17) provides that a participating state must develop a plan for medical assistance that

> include[s] reasonable standards . . . for determining *eligibility* for and the *extent of medical assistance* under the plan which . . . (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such

> individual's spouse or such individual's child who is under age 21 or . . . is blind or permanently and totally disabled, ...

42 U.S.C. § 1396a(a)(17) (emphasis added).

The statute unambiguously applies to standards for determining "eligibility" and the "extent of medical assistance." Because both eligibility and the amount of benefits received are determined by the needs standard employed, *see Morris by Simpson v. Morrow*, 783 F.2d 454, 462 (4th Cir. 1986) (eligibility for Medicaid benefits "may be ascertained only when the amount produced by the [MBU] methodology is compared against the [MNIL] standard"), subsection (17)(D) clearly applies to both income determination and needs assessment.

B

Next Appellants claim that the DHS's proposed proration policy does not impermissibly assume the availability of income, but merely takes into account that the amount of money needed to satisfy a recipient's needs is diminished because of the economies of scale associated with group living. As the DHS argues, "[p]rorating of the MNIL among mini-budget units within a family simply reflects the 'common sense proposition that individuals living with others usually have reduced per capita costs because many of their expenses are shared.'" (quoting *Brown v. Gilliard*, 483 U.S. 587, 599 (1987) (internal citation omitted)).

The district court properly found that the proration proposal did in fact lead to deeming, because "the State is implicitly assuming that household members not financially responsible for the applicant are contributing to the applicant's living expenses and thus reducing the applicant's level of need—without inquiring into whether such contributions actually are made." June 8 Order at 8. As the court recognized, the economies of scale argument

> is premised on the assumption that contributions from members of the household that are not financially responsible for the applicant are nonetheless *actually* benefitting [sic] the applicant by reducing the amount of income resources that [the] applicant needs for non-medical essentials. This is exactly the assumption that section (17)(D) does not allow the State to make.

Id. at 8-9; *accord Van Lare v. Hurley*, 421 U.S. 338, 346 (1975); *Houston Welfare Rights Org., Inc. v. Vowell*, 555 F.2d 1219, 1224 (5th Cir. 1977), *rev'd on other grounds sub nom. Chapman v. Houston Welfare Rights Org., Inc.*, 441 U.S. 600 (1979); *Swift v. Toia*, 461 F. Supp. 578, 581-82 (S.D.N.Y. 1978), *aff'd sub nom. Swift v. Blum*, 598 F.2d 312 (2d Cir. 1979) (per curiam), *cert. denied*, 444 U.S. 1025 (1980); *Garley v. Wohlgemuth*, 421 F. Supp. 1337, 1347 (E.D. Pa. 1976).

Appellants seek to distinguish these decisions by pointing out that each involved proration based on the presence of individuals from outside the family unit, while California "only prorates on the basis of the number of persons in the assistance unit" and does not deem any income or contributions from outside that unit. Secretary's Opening Brief at 8. As the district court found, however, subsection (17)(D) does not distinguish between members of the filing unit and those outside the unit. *See Olson v. Norman*, 830 F.2d 811, 817 (8th Cir. 1987); *Vance*, 793 F.2d at 1024. Moreover, because, as Appellants concede, a filing unit must be defined as an MBU to avoid running afoul of subsection (17)(D), any contributions from non-responsible family members would result in deeming from "outside" the unit. Finally, the Ninth Circuit has twice held that by reducing needs standards to reflect the fact that a public assistance recipient lives with a non-financially responsible relative, states engage in prohibited deeming. *See Beaton v. Thompson*, 913

F.2d 701, 704 (9th Cir. 1990); *McCoog v. Hegstrom*, 690 F.2d 1280, 1287 (9th Cir. 1982).

IV

Appellants also contend that the district court's suggested methodology for determining the MNIL conflicts with both 42 U.S.C. § 1396b(f), the "Federal Financial Participation" cap, as well as with 42 U.S.C. §§ 1396a(a)(10)(C) and 1396a(a)(17). We decline to reach these questions. The district court never ordered appellants to adopt the methodology it outlined. Rather, it "invite[d] [DHS] to devise a needs methodology that is consistent with section (17)(D)" and suggested, in broad terms, what such a methodology might require. *See* June 8 Order at 17-18. The court recognized that its proposal might "present problems not envisioned by the Court" and admonished that "further exploration is warranted." *Id.* at 18. Because the court did not require DHS to adopt its methodology, we have no occasion to review that aspect of the court's order.

V

Lastly, we address Appellee's request for attorneys fees against state Appellants, pursuant to 42 U.S.C. § 1988, and against federal Appellants, pursuant to the Equal Access to Justice Act, 28 U.S.C. § 2412(b) and (d). We deny both requests. Section 1988 permits a court to award attorneys fees in actions brought to enforce section 1983 and other specific civil rights laws. *See* 42 U.S.C. § 1988 (1988). This action was not brought under any of those laws and so Appellees have no remedy against state Appellants under section 1988. It follows, therefore, that Appellees also have no remedy against federal Appellants under section 2412(b). *See Lauritzen v. Lehman*, 736 F.2d 550, 553-59 (9th Cir. 1984) (fees available under section 2412(b) for civil rights violations only when fees would be available under a pre-existing statute). Finally,

we decline to award fees under section 2412(d) because the Secretary's position had a reasonable basis in law and fact, and thus was "substantially justified" for the purposes of that statute. *See Pierce v. Underwood*, 487 U.S. 552, 565 (1988).

VI

For the reasons expressed above, the order of the district court rejecting the DHS's proposal for determining MNIL's is

AFFIRMED.

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 90-15141

D.C. No. CV-89-1932-TEH

CURTIS SNEEDE, by his guardian ad litem Georgia Thompson; JUSTIN THOMPSON, by his guardian ad litem Georgia Thompson; GEORGIA THOMPSON, on her own behalf and as representative of her sons Curtis Sneede and Justin Thompson,

Plaintiffs-Appellees,

v.

KENNETH KIZER, Director, California Department of Health Services; CALIFORNIA DEPARTMENT OF HEALTH SERVICES; JESSE R. HUFF, Director, California Department of Finance; CALIFORNIA DEPARTMENT OF FINANCE,

Defendants-third-party-plaintiffs-Appellants.

Nos. 90-16143
90-16144

CURTIS SNEEDE, by his guardian ad litem Georgia Thompson; JUSTIN THOMPSON, by his guardian ad litem Georgia Thompson; GEORGIA THOMPSON, on her own behalf and as representative of her sons Curtis Sneede and Justin Thompson,

Plaintiffs-Appellees,

v.

KENNETH KIZER, Director, California Department of Health Services; CALIFORNIA DEPARTMENT OF HEALTH SERVICES; JESSE R. HUFF, Director, California Department of Finance; CALIFORNIA DEPARTMENT OF FINANCE,
Defendants-Appellants,

v.

LOUIS W. SULLIVAN, M.D., Secretary, United States Department of Health & Human Services; DEPARTMENT OF HEALTH & HUMAN SERVICES,
Third-party-defendants.

No. 90-16295

CURTIS SNEEDE,
Plaintiff,

v.

KENNETH KIZER; CALIFORNIA DEPARTMENT OF HEALTH SERVICES;
Defendants-third-party-plaintiffs-Appellees,

v.

LOUIS W. SULLIVAN, M.D., Secretary, United States Department of Health and Human Services,
Third-party-defendant-Appellant.

ORDER

[Filed Apr. 13, 1992]

Before: D.W. NELSON, HALL, and FERNANDEZ
Circuit Judges.

The panel has voted to deny appellees' petition for rehearing and to reject the suggestion for rehearing en banc.

The full court has been advised of the suggestion for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C89-1932 TEH

Class Action

CURTIS SNEEDE, by his guardian ad litem Georgia Thompson; JUSTIN THOMPSON, by his guardian ad litem Georgia Thompson; GEORGIA THOMPSON, on her own behalf and as representative of her sons Curtis Sneede and Justin Thompson,

Plaintiffs,

v.

KENNETH KIZER, Director, California Department of Health Services; CALIFORNIA DEP'T OF HEALTH SERVICES; JESSE R. HUFF, Director, California Department of Finance; CALIFORNIA DEPARTMENT OF FINANCE; LOUIS W. SULLIVAN, M.D., Secretary United States Department of Health and Human Services; UNITED STATES DEP'T OF HEALTH AND HUMAN SERVICES,

Defendants.

KENNETH KIZER, *et al.*,
Defendants and
Third Party Plaintiffs

v.

LOUIS W. SULLIVAN, M.D., Secretary, United States Department of Health and Human Services,

Third Party Defendant.

DECISION AND ORDER

[Filed Jan. 5, 1990]

[Entered in Civil Docket 1-11-90]

This matter came before the Court on January 4, 1990, on plaintiffs' motion for partial summary judgment against the State defendants. There being no dispute of material facts, and plaintiffs having demonstrated entitlement to relief as a matter of law, the motion is granted for the reasons set forth below. Fed. R. Civ. P. 56; *Celotex Corp. v. Catrett*, 477 U.S. 317, 325, 106 S.Ct. 2548 (1986); *California Architectural Building Products, Inc. v. Franciscan Ceramics, Inc.*, 818 F.2d 1466, 1468 (9th Cir. 1987), *cert. denied*, 484 U.S. 1006 (1988).

I

Curtis Sneede, on behalf of all similarly situated California residents,[1] challenges California's method for determining eligibility for Medi-Cal benefits. He contends that California, pursuant to section 50373 of the Cali-

---

[1] A California class was certified by stipulated order on July 5, 1989. The class definition was modified by order of the Court on December 5, 1989, upon plaintiffs' unopposed motion to expand the definition of the class. As currently defined, the class consists of all California residents who, at any time on or after May 18, 1988 (for purposes of prospective relief) (1) applied for and/or received Medi-Cal benefits, or will apply for and/or receive such benefits; and (2) had or will have income or resources attributed to them from an individual other than a natural or adopted parent or a spouse; and (3) have been or will be determined to be ineligible for Medi-Cal on the basis of such resources; or (4) have been or will be determined to have a share of cost.

Plaintiffs first amended complaint (filed November 28, 1989) also seeks to represent a class of similarly situated individuals residing in all states within the jurisdiction of the Ninth Circuit Court of Appeals. (Amended Complaint at 3). No certification of this circuit-wide class has yet been sought.

fornia Code of Regulations (22 C.C.R. § 50373), improperly attributes income and resources to Medi-Cal applicants and recipients from sources it is not allowed to under federal law. As a result, indigent persons are denied, in part or whole, medical assistance to which they would otherwise be entitled.

At this juncture, plaintiffs seek a partial summary judgment against the State defendants that 22 C.C.R. § 50373 is invalid. They also seek state-wide injunctive relief, but suggest deferring issues concerning implementation procedures and retroactive relief to future proceedings. No relief is sought against the Federal defendants at this time.[2]

---

[2] Plaintiffs' amended complaint challenges the validity of an August 18, 1989 transmittal from the United States Department of Health and Human Services to all Medicaid state agencies. Plaintiffs contend that the transmittal requires states to presently enact regulations similar or identical to California's existing regulations. Accordingly, the amended complaint names as defendants the Secretary of the Department of Health and Human Services as well as the Department itself (collectively referred to as the Federal defendants), and circuit-wide relief.

While the amended complaint did not alter the claim which is the subject of this motion, federal defendants sought to forestall its consideration pending development of new federal regulations which may or may not incorporate the position taken in the August 18, 1989 transmittal. The Court rejected this suggestion as calling for lengthy and unnecessary delay. However, Federal defendants were provided an additional period to participate in the briefing on the instant motion given their potential interest in its resolution. *See* December 5, 1989 Order at 2. On December 14, 1989, Federal defendants responded that "the [instant] motion . . . is premised upon allegations set forth in plaintiffs' original complaint and does not challenge the validity of any Federal statute, regulation, policy or practice. *Therefore, Federal defendant takes no position with respect to this motion.*" Federal Defendants' Response to Plaintiffs' Motion for Partial Summary Judgment at 1 (emph added). At argument, Federal defendants again declined to take any position on the merits of the motion. Accordingly, there is no basis for further delaying resolution of the issues raised at this time.

II

As a voluntary participant in the federal Medicaid program, California receives federal funding to provide medical assistance to needy persons.[3] In return, California must comply with various state plan requirements set forth in 42 U.S.C. § 1396a(a). *Cubanski v. Heckler*, 781 F.2d 1421, 1423 (9th Cir. 1986). That section provides, in pertinent part, that:

> "A State plan for medical assistance must—
>
> . . . . (17) include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . .
>
> (D) *do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 . . .*"

42 U.S.C. § 1396a(a)(17)(D) (emph. added).

This provision unambiguously limits financial responsibility for medical care to parents and spouses, for purposes of computing Medicaid eligibility. Thus, income and resources of a *spouse* are to be considered when determining the eligibility of the other *spouse*, and income and resources of a *parent* are to be considered when determining the eligibility of a *child*. In the absence of actual contribution, however, income from any other individual can not be considered. *See also*, 42 C.F.R. § 435.602.[4]

---

[3] The Medicaid program is known in California as Medi-Cal.

[4] California Welfare & Institutions Code § 14008 also comports with § (17)(D). It provides in pertinent part,

> (a) No relative, other than the spouse, shall be held to be financially responsible for the cost of health care received by an adult . . .
>
> (b) No relative, other than the parent or parents of a child under the age of 18 years, shall be held to be financially re-

The Ninth Circuit Court of Appeals recently examined subsection (17)(D) in *Vance v. Hegstrom*, 793 F.2d 1018 (9th Cir. 1986) and found that it prohibited mandatory consideration of sibling income in computing eligibility for Medicaid. While acknowledging that 42 U.S.C. § 1396a(a)(17)(B) grants the "Secretary broad powers to set standards to determine what income is available to a Medicaid recipient," 793 F.2d at 1020, the Court readily concluded that the unequivocal language of subsection (17)(D) precludes consideration of any income outside the spousal and parent-child relationships, including sibling income:

> The *plain language* of subsection 17(D) explicitly prohibits the deeming [5] of income from persons other than a Medicaid applicant's spouse, or a parent in the case of a child who is under twenty-one, blind or permanently and totally disabled. There is no clearly expressed legislative intent to the contrary.

793 F.2d at 1024 (emph. added). *See also, Malloy v. Eichler*, 860 F.2d 1179, 1184 (3rd Cir. 1988) (noting "Congress's *clear expression* of its intent [in § 1396a(a)(17)(D)] that income should not be presumed available to others in the Medicaid context outside the parent-child and spousal relationships") (emph. added). The *Vance* Court specifically rejected the argument that Congress actually intended the family, as a unit, to be responsible for medical expenses, noting that there was no legislative history to support such a conclusion. *Id.*[6]

---

sposible for the cost of health care or related services received by such child . . .

[5] Deeming income "allows the state to assume that income is available to an applicant, regardless of whether the income is actually available." *Vance*, 793 F.2d at 1029, n.1. (footnote not in original).

[6] *Vance* was subsequently followed by numerous other jurisdictions. *See Malloy v. Eichler*, 860 F.2d 1179, 1180 (3rd Cir. 1988); *Mitchell v. Lipscomb*, 851 F.2d 734, 735 (4th Cir. 1988); *Sundberg v. Mansour*, 847 F.2d 1210 (6th Cir. 1988) (aff'g district court

Despite the "plain language" of section 1396a(a)(17)(D), and the teachings of *Vance*, California's regulations impose financial responsibility for medical care on persons other than spouses and parents. Thus, California deems income and resources, for purposes of Medicaid eligibility, from (a) stepparents to stepchildren, (b) from children to parents, (c) from children to their siblings, and half-siblings, (d) between unmarried persons who are cohabiting, (f) from unmarried persons to the children of individuals with whom they are cohabiting, and (g) from children to unmarried persons with whom their parents are cohabiting.

Specifically, 22 C.C.R. § 50371 provides that the Multi Benefit Family Unit [MFBU] is "the basic unit of persons considered in determining a person's or family's [Medi-Cal] eligibility . . ." Thus, in general, the income and resources of all persons in the MFBU are considered in determining Medicaid eligibility for any MFBU member. The regulations further provide that "*all family members living in the home . . . shall be included in the [Multi Benefit Unit]* . . . whether or not they are eligible for, or wish to receive, Medi-Cal." 22 C.C.R. § 50373(a)(2) (emph. added). Section 50373(a)(5) applies this principle to a variety of household configurations, with the results described above.[7]

---

upon divided vote of *en banc* panel); *State of Georgia Dep't of Medical Assistance v. Bowen*, 846 F.2d 708 (11th Cir. 1988); *Childress v. Bowen*, 833 F.2d 231 (10th Cir. 1987); *Olson v. Norman*, 830 F.2d 811 (8th Cir. 1987); *Reed v. Blinzinger*, 816 F.2d 296 (7th Cir. 1987).

[7] Thus, with respect to children living with a natural parent, except in certain circumstances, all members of the household, including siblings, half-siblings, the natural parent, and the spouse or unmarried partner of the parent are required to be in a single MFBU, in order for any member of the household to receive full Medi-Cal services.

In the case of unmarried parents who are living together, each parent may be in a separate MFBU with his or her children, but their mutual children will not then be eligible for Medicaid.

III

We agree with plaintiffs that 22 C.C.R. § 50373 violates 42 U.S.C. § 1396a(a)(17)(D). The "plain meaning of the words chosen by Congress is controlling in the absence of a clearly expressed legislative intent." *Vance*, 793 F.2d at 1023. As discussed above, and as the Ninth Circuit has held, subsection (17)(D) is unambiguous: states may not deem income and resources from *any* individual (absent actual contribuiton) except from a spouse to a spouse or a parent to a child for purposes of computing Medicaid eligibility. There is no clearly expressed contrary legislative intent. *Vance*, 793 F.2d at 1024. Accordingly, the plain meaning of § 1396a(a)(17)(D) controls, and California must discontinue its contrary practices.

Significantly, the State defendants make no serious effort to reconcile 22 C.C.R. § 50373 with the language of § 1396a(a)(17)(D). Rather, they argue that California's regulations should be upheld because they are not inconsistent with proposed regulations recently published by the Secretary of the Department of Health & Human Services. However, given the lack of ambiguity in § 1396a(a)(17)(D), and the authority cited above, the fact that California's regulations may comport with as yet unadopted federal regulations—the validity of which is also open to challenge (*see* n. 2, *supra*)—has little persuasive value.

California also points to a "voluntary child exclusion provision" to demonstrate that California's regulations avoid the mandatory sibling deeming found objectionable by the Ninth Circuit in *Vance*. As explained, below, however, California's attempt to distinguish, or perhaps more accurately circumvent, *Vance* based on this provision, is unavailing.

If a married couple has mutual and/or separate children, section 50373 generally requires that all of the

children be in the same MFBU—which results in the improper deeming of income between full, half, and step siblings. The "voluntary child exclusion provision," embodied in 22 C.C.R. § 50381, allows parents the option of excluding a child from the MFBU if the child has separate income (e.g. child support or social security) or property. Although the child's income will then not be deemed to other family members (consistent with § (17)(D)), the *excluded child will then be precluded from applying for Medi-Cal benefits*, even if the child's income is insufficient to cover necessary medical expenses. 22 C.C.R. § 50381. Conversely, if the family "voluntarily opts" keep the child in the MFBU, so that s/he may apply for Medi-Cal benefits, the child's assets *will be deemed to other family members, in the MFBU*, contrary to the express language of § 17(D).

We acknowledge that *Vance* struck a rule which *mandated* consideration of sibling income, where as this particular result can be avoided in California by "voluntarily excluding" children from a MFBU, but *the child must then forego any Medicaid assistance.* This sort of conditional "voluntary exclusion provision" is just as inconsistent with the unqualified language of subsection (17)(D) as a mandatory rule. There is not the slightest hint that Congress' plainly expressed deeming limitations may be ignored because a child seeks Medicaid assistance.[8] Stated differently, there is not the slightest hint that Congress only intended subsection (17)(D) to apply if the family pays the price of excluding its children from eligibility for Medicaid. Simply put, section (17)(D) does not permit imposition of such a Hobson's choice.

---

[8] As explained earlier, in order for the child to receive Medi-Cal benefits, s/he must be included in the MFBU. As a result, his/her income and resources will be deemed to other family members in contravention of subsection (17)(D).

California also points to a similar "voluntary stepfamily exclusion provision" as a means for avoiding stepparent deeming prohibited by subsection (17)(D). However, this exclusion provision is no more helpful to California than the "child exclusion provision" discussed above.

Normally, section 50373 requires that, in stepparent families, all of the couple's mutual and separate children be with them in the same MFBU, which results in improper deeming between stepparents and stepchildren. The "stepfamily exclusion provision" allows a stepfamily household to elect to receive Medi-Cal benefits *only for the separate child(ren) of one parent*. 22 C.C.R. § 50375. If this option is elected, only the separate children and the ineligible natural parent would be included in the MFBU, and thus only their income would be considered (consistent with § (17)(D)). *Id.*[9] However, *no other family members* (besides the separate children of one parent) *can then apply for Medi-Cal benefits*. *Id.* Conversely, in order for other family members to receive medicaid assistance, all members must be included in the MFBU and thus subject their income and resources to deeming beyond that allowed by subsection (17)(D). Again, there is simply no basis for concluding that subsection (17)(D)'s deeming restrictions need only be observed where the stepfamily "voluntarily chooses" to limit medicaid assistance to the separate children of one parent.

In short, section 50373 does not mandate the deeming of sibling and stepparent income, given the "voluntary exclusion" options described above. It is no less invalid, however, than the mandatory rule struck in *Vance* because the only way to avoid improper sibling or stepparent deeming is to preclude children and/or other family members from applying for Medicaid. And if the above

[9] A portion of the stepparent's income, however, is still attributed to the spouse, under 22 Cal. Reg. §§ 50559-50561, and therefore indirectly attributed to the spouse's separate children.

authorities make anything clear, it is that section 1396a(a)(17)(D) sets forth an absolute rule, the applicability of which does not hinge on precluding a child or any other member of the family from applying for Medicaid. Thus, the State's attempt, in effect, to restrict application of subsection (17)(D), through back door conditions nowhere contemplated by Congress, must be rejected. Indeed, we conclude that the "voluntary exclusion provisions," rather than demonstrating compliance with subsection (17)(D), only serve to highlight the State's disregard for a clear and unconditional federal law.[10]

Moreover, even assuming a family chose to utilize one or both of the exclusions, California regulations would still result in improper deeming. For example, these ex-

---

[10] It is also highly questionable whether the "choices" presented by the voluntary exclusion provisions can be exercised in a truly voluntary fashion. If a child has any significant medical needs, his/her inclusion in the MFBU will most likely be a matter of economic necessity rather than a "voluntary choice." Consequently, the family will, in effect, be forced to accept unlawful deeming of that child's income to other family members. The named plaintiff's circumstances in this case are illustrative of the dilemmas posed by California's regulations.

Curtis Sneede, developmentally disabled, is the adopted son of Mrs. Thompson alone. Mr. and Mrs. Thompson also recently had a natural child, Justin. Under §§ 50373 and 50381, Mrs. Thompson would have had to forego Medi-Cal for Curtis Sneede, despite his medical needs, in order to avoid deeming of his social security income to Justin and herself, which would adversely affect their level of Medi-Cal assistance. The family could have applied for Medi-Cal for Curtis alone (under the stepfamily exclusion), and thereby avoided the deeming of Curtis' stepfather's pension and social security income to Curtis, prohibited by section 1396a(a)(17)(D); however, Mrs. Thompson would then have had to forego Medi-Cal benefits for her complicated pregnancy and delivery, because under the "stepfamily exclusion provision" only the separate children of one parent are eligible for Medi-Cal benefits. To conclude that this family would have "voluntarily" included either Curtis or Mrs. Thompson in the MFBU would be to indulge in fiction over fact.

clusions would not affect that portion of section 50373 which provides for the deeming of income between unmarried persons who are cohabiting. And as noted above, under the stepfamily exclusion provision, some stepparent income may still be improperly deemed to stepchildren through the spouse.

Finally, we observe that the implicit premise underlying the State's position—that as a matter of policy, total family resources should be considered when determining Medicaid eligibility, regardless of actual contribution—has met with consistent rejection by the courts.

For example, in *State of Georgia Dep't of Medical Assistance v. Bowen*, 846 F.2d 708 (11th Cir. 1988) the Eleventh Circuit Court of Appeals rejected the argument that, by expanding deeming rules for the Aid to Families with Dependent Children program [AFDC], Congress intended to graft a "nuclear family responsibility" requirement into the Medicaid Act despite the plain meaning of section 1396a(a)(17)(D):

> We are simply unwilling to presuppose that when Congress changes AFDC eligibility standards, it intends also to change Medicaid eligibility standards. Indeed, that it is logical to differentiate between AFDC eligibility and Medicaid eligibility is reflected by the nature of the benefits. The kind of benefits for which AFDC provides, housing and food, are shared by family members, so it could be argued that all of the financial resources of teh family should be pooled in determining whether AFDC assistance is required. Medicaid benefits, however, are not shared in this manner, but rather pay for individual health care only, and do not become a part of a common resource. *Thus, while the policy that all family members should contribute to the family's communal expenses may be persuasive in the AFDC context, it has no applicability in the Medicaid context where the assistance is not used for a communal expense.*

846 F.2d at 712; *See also, Malloy*, 860 F.2d at 1184 (same reasoning); *Vance*, 793 F.2d at 1024 (rejecting application of nuclear family concept to Mediciad program); *Ward v. Wallace*, 652 F. Supp 301, 305-06 (M.D. Ala. 1987), *amended*, 658 F.Supp. 441 (same). Thus, section 50373 can not be defended on the ground that Congress actually intended to impose responsibility for medical care on all family members.

III

In light of all the foregoing, it is HEREBY ORDERED as follows:

1. Plaintiffs' motion for a partial summary judgment that 22 C.C.R. § 50373 violates 42 U.S.C. § 1396a(a)(17)(D) is GRANTED.

2. Defendants Department of Health Services (hereinafter "DHS") and Kenneth Kizer are HEREBY ENJOINED from enforcing any rule or policy that results in consideration, in the absence of an actual contribution, of the income or resources of any individual other than a parent of a child who is under twenty-one, blind or disabled, or a spouse for purposes of determining eligibility or the amount of the share of cost of any other individual who is applying for or receving Medi-Cal benefits.

3. Within 30 days of the date of this order, defendants DHS and Kizer shall confer with plaintiffs' counsel and attempt to reach agreement with respect to instructions for implementing this order. In the event that agreement is reached, the instructions shall be filed with this Court and transmitted to California county welfare departments no later than 45 calendar days from the date of this order. If no agreement is reached, plaintiffs and defendants DHS and Kizer shall each file proposed instructions together with a supporting memorandum on or before 45 calendar days from the date of this order. Opposing memorandum shall be filed within 10 calendar

days of service of the proposed instructions. The matter will then be deemed submitted on the papers unless the Court orders otherwise.

4. Within five working days from the date of this order, defendants DHS and Kizer shall instruct California county welfare departments to identify the members of the class, as certified by this Court's order of December 5, 1989. Defendants DHS and Kizer shall instruct such welfare departments to complete identification of the aforesaid persons within 60 days from the date of this order. Prior to sending such instructions, defendants DHS and Kizer shall provide plaintiffs' counsel with a reasonable opportunity to comment on them. In the event that plaintiffs conclude that the instructions are deficient, they may seek further relief from this Court.

IT IS SO ORDERED.

Dated 1/5/90,

/s/ Thelton E. Henderson
Judge THELTON E. HENDERSON
United States District Court

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C89-1932 TEH
Class Action

CURTIS SNEEDE, by his guardian ad litem Georgia Thompson; JUSTIN THOMPSON, by his guardian ad litem Georgia Thompson; GEORGIA THOMPSON, on her own behalf and as representative of her sons Curtis Sneede and Justin Thompson,

Plaintiffs,

v.

KENNETH KIZER, Director, California Department of Health Services; CALIFORNIA DEP'T OF HEALTH SERVICES; JESSE R. HUFF, Director, California Department of Finance; CALIFORNIA DEPARTMENT OF FINANCE; LOUIS W. SULLIVAN, M.D., Secretary, United States Department of Health and Human Services; UNITED STATES DEP'T OF HEALTH AND HUMAN SERVICES,

Defendants.

KENNETH KIZER, *et al.*,
Defendants and
Third Party Plaintiffs,

v.

LOUIS W. SULLIVAN, M.D., Secretary, United States Department of Health and Human Services,

Third Party Defendant.

ORDER

[Filed Jun. 8, 1990]

BACKGROUND

On January 5, 1990, this Court granted plaintiffs' motion for partial summary judgment against the State defendants [1] after finding that California's methodology for determining Medi-Cal eligibility for the "medically needy" [2] violated federal law. The Court further ordered the parties to confer with respect to appropriate implementing instructions. Agreement was reached with respect to all but one, albeit significant, aspect of such instructions. After supplemental briefing and argument, the Court now addresses this remaining disagreement.[3]

As with the partial summary judgment motion, the instant dispute turns on interpretation of 42 U.S.C. § 1396a(a)(17)(D). That section provides, in pertinent part, that:

> A State plan for medical assistance must—. . . .(17) include reasonable standards . . . for determining *eligibility* for and the extent of medical assistance under the plan which . . .
>
> (D) *do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or*

[1] Decision reported at 728 F.Supp. 607 (N.D.Cal. 1990). The background to this action is set forth in that decision and will not be repeated here.

[2] "Medically needy" recipients are those who would qualify for "Supplemental Security Income" ("SSI") benefits or "Aid to Families with Dependent Children" ("AFDC") benefits but for the fact that their income is too high. 42 U.S.C. § 1396a(a)(10)(C)(i). "Categorically needy" recipients—which are not involved in this action—are those recipients who receive cash benefits (SSI or AFDC). 42 U.S.C. § 1396a(a)10(A)(i). In California, categorically needy persons automatically qualify for Medi-Cal. Cal. Welfare & Inst. Code § 14005.1.

[3] Although the Secretary of Health and Human Services, a third-party defendant, is not a party to the instant dispute, he has filed comments on the State's Plan for the Court's consideration.

> *such individual's child who is under age 21* . . . or is blind or permanently and totally disabled . . .

42 U.S.C. § 1396a(a)(17)(D) (emph. added). As explained below, the parties disagree as to how this provision impacts upon one aspect of the eligibility process—determination of the appropriate "needs" standard.

A "medically-needy" applicant's eligibility for Medi-Cal is determined in a three step process. First, the State determines who is in the "Medi-Cal Family Budget Unit" or "MFBU." Second, the State computes the MFBU's net non-exempt income (hereafter simply "income"). In its January 5, 1990 decision, the Court ruled that California could no longer determine the composition of MFBUs based on the more liberal AFDC standard unit filing rules [4]; rather MFBUs must be composed in a manner consistent with section 1396a(a)(17)(D). Thus, MFBUs must be defined such that the income of persons other than the spouse or parent is not deemed [5] to the MediCal applicant.

The instant dispute concerns the third and final step of the eligibility process. Once the income for the MFBU is ascertained, that income is measured against a "needs" standard referred to as "Medically Needy Income Levels" or "MNILs." The MNIL, which varies by number of people, represents the amount of income considered necessary to cover all basic non-medical needs for food, clothing

---

[4] In 1984, as part of the Deficit Reduction Act, Congress broadened who must be included in a unit applying for AFDC benefits. Such budget units must now include parents, brothers, sisters, and half-brothers and sisters. 42 U.S.C. § 602(38). In 1980, Congress specifically allowed states to prorate AFDC needs standards to account for persons who were living in the same household as the recipient but were outside the unit. 42 U.S.C. § 612.

[5] "Deeming" allows the state to assume that income or resources are available to an applicant without inquiring into whether such income or resources are actually available.

and shelter.[6] Under the State's current regulations, MFBU income is compared to the corresponding MNIL for the number of persons in the MFBU. 22 Cal. Code of Regs. §§ 50371, 50653. For example, the income of an MFBU consisting of one person is compared to the MNIL for one person.

If the MFBU income exceeds the corresponding MNIL, then the applicant must pay this amount as a "monthly deductible" before Medi-Cal will cover remaining medical expenses. (This "monthly deductible" is referred to as a "share of cost" or "SOC"). Conversely, if the MNIL exceeds the MFBU's income, then no share of cost is required.

Prior to this action, California included various configurations of household members in one MFBU consistent with AFDC standard filing rules. *Sneede*, 728 F.Supp. at 609-10. The result was that income was deemed to applicants from persons other than a spouse or parent. Our January 5, 1990 decision found, however, that section 1396a(a)(17)(D) "unambiguously limits financial responsibility for medical care to parents and spouses" 728 F.Supp. at 609, and that such deeming was therefore unlawful. Accordingly, the Court invalidated the State's AFDC-based MFBU composition rules and required that persons previously in one MFBU now be placed in as many separate MFBUs as necessary to avoid unlawful deeming.

All parties agree that the MFBU composition rules have now been satisfactorily modified to preclude any unlawful deeming of income within units in violation of section (17)(D). The dispute arises at the point when the income for the MFBU is compared to the MNIL. State defendants (joined by federal defendants) propose that

---

[6] The current MNILs are $600 for 1 person, $750 for two persons (at least one not an adult), $934 for two adults or three persons, $1,100 for 4 persons, $1,259 for five persons, and $1,417 for 6 persons.

the MNIL should be determined by the number of people who would have been included in the old, now-invalidated AFDC-based MFBU—and then prorated by that same number of people. For example, if the old, invalidated MFBU consisted of five persons, but under the new rules, there will be two smaller MFBUs (one consisting of three, the other consisting of two, persons) then the MNIL for each applicant in the household would be one fifth of the MNIL for five persons or $251.80 ($1,259 divided by five). In other words, defendants argue that while the invalidated MFBU's must, consistent with our January 5th order, be "disaggregated" for purposes of determining income available to Medi-Cal applicants, once that determination is made the household should then be "re-aggregated" into the invalid AFDC-based MFBU for purposes of determining need levels.

Under plaintiffs' counter-proposal, each new MFBU would be compared to the MNIL for the number of persons in the new MFBU. Thus the new three-person MFBU would be compared to the MNIL for three, and the new two-person MFBU would be compared to the MNIL for two.

Plaintiffs object to the State's proposal on the ground that it will again result in improper deeming in violation of section (17)(D), whereas their proposal will not. The State, on the other hand, urges the Court to reject plaintiffs' proposal because it is not required by section (17)(D), and will significantly increase program costs in contravention of 42 U.S.C. § 1396b(f)(1)(B). It disputes that its proposal involves any deeming prohibited by section 17(D).

After careful consideration, and for the reasons explained below, we conclude that plaintiffs' objections to the State's plan are valid; however, we also conclude that plaintiffs' proposed alternative deviates from the dictates of section (17)(D) as well, albeit for different reasons.

Thus, we direct the parties to attempt to devise a new proposal consistent with this Order.

DISCUSSION

A. *The State's Proposal*

As noted above, the State can not, in determining "eligibility" for Medi-Cal benefits, take into account the "financial responsibility" of any individual for the applicant, absent a showing of actual contribution,[7] with the following two exceptions: parents are financially responsible for minor children and spouses are financially responsible for each other. 42 U.S.C. § 1396a(a)(17)(D). In short, financial contributions may only be deemed to applicants within the confines of spousal or parent/minor child relationship.

Defendants argue that the above financial responsibility restriction applies *only* when the state is calculating income available to the applicant/MFBU (step one of the eligibility process), and not when the state makes the needs assessment (step three). The plain language of the statute, however, defeats this argument.

Section (17)(D), itself, makes no reference to "income"; nor does it hint that the state can choose to abide by the financial responsibility restriction for just one aspect of the eligibility determination. Rather, the express terms of the statute are broader. Specifically, the plain meaning of the term "eligibility" means *all* aspects of the eligibility process; the plain meaning of the term "financial responsibility" encompasses *any* financial assistance. In short, the plain meaning of section 1396a(a)(17)(D) is that the state may not, in determining eligibility,

[7] Of course, nothing in this Court's decisions precludes the State from inquiring into whether actual income/resource contributions are made from non-financially responsible persons to others in the household.

assume the financial responsibility of any person for the applicant (except for parents/spouses)—whether that financial responsibility is in the form of income attributable to the applicant or in the form of contributions to the applicant's basic living expenses.[8]

The State's proposal, however, leads exactly to this result. In basing the MNIL on the old, invalidated MFBU, and then pro-rating it, the State is implicitly assuming that household members not financially responsible for the applicant are contributing to the applicant's living expenses and thus reducing the applicant's level of need—without inquiring into whether such contributions are actually made.

The State contends that it would not be engaging in unlawful deeming, but simply taking into account "economies of scale" that occur when persons share a household. However, the economies of scale argument is *premised* on the assumption that contributions from members of the household that are not financially responsible for the applicant are nonetheless *actually* benefitting the applicant by reducing the amount of income/resources that applicant needs for non-medical essentials. This is exactly the assumption that section 17(D) does not allow the State to make.

A line of cases involving the AFDC program (before AFDC rules were changed to allow for broader deeming than that allowed in the Medicaid program, see n.4 *supra*) supports the conclusion that reducing the needs standard to account for contributions from non-legally responsible individuals constitutes unlawful deeming.

For example, in *Houston Welfare Rights Organization, Inc. v. Vowell*, 555 F.2d 1219 (5th Cir. 1977), *rev'd on other grounds sub nom. Chapman v. Houston Welfare*

---

[8] *See also*, H.Rep. 213, 89th Cong., 1st Sess. 68 (1965) ([Section 1396a(a)(17)(D) would preclude states from] "requiring contributions from relatives other than a spouse or [parent])".

Rights Organization, Inc., 441 U.S. 600 (1979), the plaintiffs challenged a proration policy which presumed that noneligible individuals living with the recipient contributed toward shelter and utility expenses, thus reducing the need of the recipient. 555 F.2d at 1222. The court, relying on *Van Lare* v. *Hurley*, 421 U.S. 338, 95 S.Ct. 1741 (1975), rejected the defendants' contention that it was not engaged in improper deeming but simply adjusting "needs" to account for "economies of scale":

> The presumption that a recipient's shelter and utility expenses are lowered—creating less need when a nonrecipient lives in the household implicitly presumes that the non-recipient's income is available to offset his share of the shelter and utility costs. If not, the recipients 'need,' in terms of actual shelter cost, will not decrease. The [defendant's] claim that it is only reflecting the economies of scale enjoyed by large groups living together again implicitly presumes that the nonrecipient's income will be available to offset shelter and utilities. Without that presumption, the economies-of-scale argument is irrelevant.

555 F.2d at 1224.[9] *See also, Swift v. Toia*, 461 F.Supp. 578, 580 (S.D.N.Y. 1978), *aff'd sub nom, Swift v. Blum*, 598 F.2d 312 (2nd Cir. 1979) (per curiam), *cert. denied*, 444 U.S. 1025 (1980); *Gurley v. Wohlgemuth*, 421 F.

---

[9] In *Van Lare*, the Supreme Court struck a statute which reduced the shelter allowance provided AFDC recipients on a pro rata basis to take into account the presence of a non-legally responsible "boarder." Notably, after *Van Lare*, the then Department of Health, Education, and Welfare amended its AFDC regulations to preclude use of a pro rata method for assessing needs where non-legally responsible individuals were included in the unit: "[T]he money amount of any need item included in the standard will not be prorated or otherwise reduced solely because of the presence in the household of a non-legally responsible individual; and the agency will not assume any contributions from such individual for the support of the assistance unit." 45 C.F.R. § 233.20(a)(2)(viii) (1977).

Supp. 1337, 1347 (E.D. Pa. 1976) ("The fundamental fallacy in the economies of scale argument is that, no matter how carefully it is parsed, it is in fact bottomed on a conclusive presumption that one . . . family contributed to the support of another . . . family");[10] *accord McCoog v. Hegstrom*, 690 F.2d 1280, 1287-88 (9th Cir. 1982). The State's approach has also been rejected in the Medicaid context by New York's highest court. *See Vailes v. D'Elia*, 426 N.E.2d 179, 442 N.Y.S. 2d 772, 772-773 (New York 1981) (needs standard [referred to as "income exemption"] can not be based on inclusion of persons who are not financially responsible for the applicant).[11]

Defendants also argue that section (17)(D) should be limited to income (and not needs) assessments in light of the "federal financial participation" or "FFP" provision set forth at 42 U.S.C. § 1396b(f)(1)(B). Adopted in 1968 as a cost containment measure, section 1396b (f)(1)(B) provides that "federal reimbursement for

---

[10] While AFDC rules have changed since these cases were decided (see n. 4 *supra*), the underlying principles espoused are still valid and instructive in the Medicaid arena—where the rules have not been similarly changed. Nevertheless, federal defendant attempts to distinguish these cases on the grounds that they involved deeming from persons "outside" the budget unit. However, section 1396a (a)(17)(D) does "not distinguish between members of the filing unit and those outside the unit," *Olson v. Norman*, 830 F.2d 811, 817 (9th Cir. 1987); *see also, Vance*, 793 F.2d at 1024-1026. Moreover, the State's proposal here *would* result in deeming from "outside" the unit, where the unit is defined in a manner consistent with section 1396a(a)(17)(D).

[11] A 1985 memorandum from Department of Health & Human Services to the Regional Administrator for Region IV also rejected a "pro rata" approach to MNILs. *See* Plaintiffs' Exh. 6 at 2 ("The regional office suggested that a State could prorate the medically needy income standard. This approach is arbitrary and has no foundation in AFDC policy. Under AFDC policy the income of members of the unit is applied to the needs of the members of the unit based on an income standard for the unit").

benefits provided to the medically needy [is] available only if the income of those persons, after the deduction of incurred medical expenses, [is] less than 133⅓% of the state AFDC payment level." [12] *Schweiker v. Hogan*, 457 U.S. 569, 102 S.Ct. 2597, 2608 (1982).

There is nothing on the face of section 1396b(f)(1)(B) that purports to limit the express terms of section 1396a(a)(17)(D). Defendants essentially argue, however, that because the purpose of section 1396b(f)(1)(B) was to reduce Medicaid program costs, Congress must have intended to restrict the reach of section 17(D) to income calculations only. The problem with this argument is that section 17(D) is unambiguous. Where Congress has spoken clearly, that "is the end of the matter." *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843-43, 104 S.Ct. 2778, 2781 (1984). We are not at liberty to create ambiguities, tailor statutes to conform to policy preferences, or modify language to comport with generalized cost reduction goals, where the statutory language is plain and unequivocal on its face. *Vance v. Hegstrom*, 793 F.2d 1018, 1023 (9th Cir. 1986) ("The plain meaning of the words chosen by Congress is controlling in the absence of a clearly expressed legislative intent [to the contrary]" not present here). Accordingly, we decline to justify reading section 17(D) as defendants urge based on section 1396b(f)(1)(B).

In sum, the State's proposal violates section 1396a(a)(17)(D)'s mandate that financial responsibility for the applicant be limited to parents and spouses. The State may not, in light of this restriction, continue to treat certain households as a single unit, for purposes of

---

[12] The pertinent part of the text is as follows: "the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓% of the highest amount which would ordinarily be paid to a family of the same size without any income or resources . . ."

assessing needs simply because they would be so treated under AFDC. As *Vance* makes clear, AFDC methodologies may not be utilized where, as here, it would result in deeming prohibited by section (17)(D). Nor does section 1396b(f)(1)(B) justify deviation from the plain language of that provision.[13]

B. *Plaintiffs' proposal*

Plaintiffs have submitted an alternative to the State's proposal that would require the State to use an MNIL consistent with the number of persons in the MFBU--as defined in a manner consistent with the Court's January 5, 1990 order. Thus, for example, in the case of the named plaintiff's household, Curtis Sneede and Justin Thompson would each be in their own MFBU (because they each have separate income) and the income for each of those MFBUs would be compared to the MNIL for one. Mr. and Mrs. Thompson would make up a third MFBU, and the income for that MFBU would be measured against the MNIL for two.

Defendants contend that this approach would conflict with the 133 1/3% FFP cap contained in section 1396b(f)(1)(B) and result in excessively high needs levels. We disagree with the first contention but agree with the second to a limited extent, as explained below.

Defendants' argument that plaintiffs' proposal conflicts with § 1396b(f)(1)(B) is premised on the assumption that the term "family" is defined to include whoever would be included in a standard filing AFDC unit. We decline to so interpret "family." There is no indication that Congress intended to incorporate whatever the current AFDC filing unit rules might be into section

---

[13] Because of this conclusion the Court does not reach plaintiffs' alternative arguments that the State's proposal results in impermissible "double deeming" and violates other provisions of the Medicaid Act.

1396b(f)(1)(B).[14] Indeed, courts have consistently rejected the Secretary's attempt to inject AFDC rules into the Medicaid arena, where as here, to do so would conflict with § 1396a(a)(17)(D).[15] Defendants' interpretation also creates an internal inconsistency within section 1396b(f)(1) since the term "family" in § 1396b (f)(1)(A) is plainly not intended to correlate to the AFDC standard filing unit rules.[16]

Defendants also contend that plaintiffs' proposal will inflate the needs standard because persons such as Mr. and Mrs. Thompson, who are living in a household of four, and thus enjoying economies of scale, will nevertheless be assessed as having the same basic income needs as if they were living in a household of two. Defendants' argument is undermined by the fact that, in various households unaffected by this case, the household members are placed in separate MFBUs and given MNILs

[14] Apparently, there is no legislative history illuminating the definition of "family."

[15] *See Vance*, 793 F.2d 1018, 1024-25 (rejecting argument that because Congress modified AFDC filing rules that it intended to modify Medicaid methodologies as well); *State of Georgia Dep't of Medical Assistance v. Bowen*, 846 F.2d 708, 712 (11th Cir. 1988) ("We are unwilling to presuppose that when Congress changes AFDC eligibility standards, it intends also to change Medicaid eligibility standards"); *see also*, legislative history to 42 U.S.C. § 1396a(a)(1)(3)(E) (1989 Supp.) involving "family" income standards for a recently added program involving pregnant women, infants and children, H.R. Rep. 100-391 (100th Cong. 1st Sess. (1987) at 447-48 ("[A]s in the case of categorically needy and medically needy women and children, *States must not*, in determining family income with respect to the optional categorically needy . . . *use AFDC methodologies . . . that are inconsistent with the deeming policies specific to Medicaid*").

[16] Defendants also suggest that family has a plain, ordinary, meaning that correlates to the AFDC standard filing unit rules. In the complex health and welfare benefits area, however, it is clear that there has been no one, consistent, definition of "family." Rather, it is a term of art that must be assessed within the context of the particular statute at issue.

corresponding to the MFBUs (rather than prorating the MNIL based on the total number in the household) even though those households presumably enjoy economies of scale. Yet defendants have never, and do not now, suggest that those instances result in inflated MNILs. Rather, they only invoke the economies of scale issue when the household members would be treated as a single unit under AFDC standard filing unit rules.

Plaintiffs provide several examples where, under current regulations unaffected by this case, household members are placed in separate MFBUs and given corresponding MNILs—rather than prorating the MNIL based on the total number in the household: Two sisters living together, each with one child (who has no separate income) would each have their eligibility determined using the full MNIL for two. Four aged and disabled sisters, living together, are also each allowed an MNIL for one (rather than an MNIL for four divided by four). Three unrelated foster children and their disabled or aged foster parent are also each allowed an MNIL for one. Finally, "caretaker relatives" such as aunts and grandmothers, living in the household are placed in a separate MFBU and receive the full MNIL for one. In all these examples, the need level is based on *who can be considered financially responsible for the applicant* rather than any economies of scale.

Reduced to its core, defendants' view is that plaintiffs' proposal results in excessive needs assessments because certain households would be allowed a higher combined needs allowance than if that household was considered under AFDC standard filing unit rules. This simply ignores, however, that Medicaid rules limit far more than AFDC rules, who can be considered financially responsible for the applicant(s). Needs assessments will therefore be higher for some households than others—even though the total number of people living in the household are the same—because under section 1396a(a)(17)(B)

the state must treat certain segments of certain households as being financially separate from others. In short, the "higher" needs assessments defendants complain of are not due to unjustified "inflation"; rather, they merely reflect the different financial responsibility rules that govern the Medicaid and AFDC programs.

It also appears, however, that plaintiffs' proposal would sometimes result in the use of MNILs that do not fully reflect the unit's financial responsibility under section 1396a(a)(17)(D). For example, Curtis Sneede is in a separate MFBU because he receives separate income that may not be deemed to other family members. Yet, Curtis is not solely responsible for himself; thus, it appears inappropriate to assess his income/resource needs as if he were—and thus adjudge his eligibility based on an MNIL for one. Rather, Curtis' mother, Mrs. Thompson, is also financially responsible for Curtis. Thus, her income/resource contributions can and should be considered in assessing Curtis' non-medical needs. One possible approach that would reflect this fact would be to measure Curtis' income against one half of the MNIL for two. Pro-rating is not impermissible so long as it is not based on persons not financially responsible for the applicant. By posing this suggestion, the Court does not intend to rule out other approaches. Rather, the Court invites plaintiffs and state defendants to devise a needs methodology that is consistent with section (17)(D) in that:

(1) it takes into account the applicant's needs in light of all persons who are financially responsible for the applicant under § 1396a(a)(17)(D)—whether included in the MFBU or not, but

(2) does not reduce the needs standards based on the presence of persons in the household who are not financially responsible for the applicant under § 1396a (a)(17)(D).

A needs methodology which comports with both of the above would appear to demand no more and no less than that required by § 1396a(a)(17)(D).

The Court realizes that it is suggesting a route not proffered by either party and that it may present problems not envisioned by the Court. Nevertheless, the Court is of the opinion that further exploration is warranted.

Accordingly, and good cause appearing, it is HEREBY ORDERED that:

1. plaintiffs and state defendants shall confer as soon as practicable in an effort to develop a needs methodology consistent with this order.

2. No later than 30 days from the date of this order, the parties shall file a statement (jointly or separately) indicating that (a) a proposal has been developed consistent with this order or (b) that no such proposal is feasible and the reasons why.

3. The Court will determine how to further proceed once the parties' responses have been reviewed.

IT IS SO ORDERED.

DATED 6/8/90

/s/ Thelton E. Henderson
JUDGE THELTON E. HENDERSON
United States District Court